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ABSTRACT

This article discusses the nature of resilience in children, means to measure and verify it, and attempts to promote it through education; it also describes a study of parental, teacher and caregiver efforts to promote resilience in children. The International Resilience Project examined resilience factors children and their parents use in response to constructed situations of adversity and the developmental differences in acquiring this trait. In this study, 589 children ranging in age from under 3 years to 11 years old and their parents or caregivers responded to a sample situation involving a parent and child. Subjects were from 14 countries experiencing cultural change or war. While an insignificant number of children under age 3 responded, of the children in the other 2 age groups, younger children showed less resilience in their responses than older children. Evidence of resilience-promoting behavior was found to be almost equal across parents in each age group. The article discusses reports of personal experiences in addressing adversity drawn from the study. Based on the study's findings, the article presents suggestions for effective interventions to encourage resilience in children. Resilience features are classified into three phrases. Examples of three phases are: I HAVE people around me I trust and who love me, no matter what; I AM a person people can like and love; I CAN talk to others about things that frighten me or bother me. Other sample statements using these phrases are provided. (Contains 16 references.) (JPB)

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THE INTERNATIONAL RESILIENCE PROJECT FINDINGS FROM THE RESEARCH AND THE EFFECTIVENESS OF INTERVENTIONS[1]

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Research

A shift from pathology to resilience

The recognition of resilience as a phenomenon emerged more by accident that by intent. The focus of research was primarily to determine pathological or risk factors with which children coped in life. The intent of the studies focused heavily on ways to identify the damage done to the children and to provide services to help them develop as well as possible with the risks they lived with. Those researchers who found that about one-third of the children living with such risks and pathology, but were well adjusted, happy and successful, began to wonder what was going on with them; how could the success of these children be accounted for (Werner & Smith, 1982; Garmezy, 1985).

The important reply came from William Frankenburg, M.D.,., in his opening statement at the Fifth International Conference on Early Identification of Children at Risk: Resilience Factors in Prediction. He stated:

One thing that has become clear from the four previous conferences is how often researchers and care providers alike have been caught up in a pathological model of looking at children. We have focused on looking for problems, a negative approach that may sometimes have the undesirable effect of causing parents to think negatively about their children. That is why the Fifth International Conference will focus on those resilience and "self-righting " factors - those strengths - that seem to protect some children who are at high risk for developmental handicaps (Frankenburg, 1987).

That statement captured the essence of the problems with focusing on pathology. But an additional point critical to studying resilience was made by The Bernard van Leer Foundation supported conference held in the Kingdom of Lesotho in 1991 in which the focus was Building on People's Strengths: Early Childhood in Africa (The Bernard van Leer Foundation, 1994). Other national and international meetings on resilience followed these seminal meetings with a clearer view of what was involved with children who overcame the odds, i.e., became competent, well adjusted children and adults in spite of the risks and adversities they faced.

The coalescing views entailed recognizing some traits and characteristics these resilient children had that were different from or not as frequently found in children who were not resilient. The traits were identified by different researchers and practitioners, but there was growing consensus on their

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identification. The International Resilience Project organized those traits into the following categories: External supports and resources, including trusting relationships; access to health, education, welfare and security services; emotional support outside the family; structure and rules at home; parental encouragement of autonomy; stable school environment; stable home environment; role models; and religious organizations (morality); Internal, personal strengths, including a sense of being lovable; autonomy; appealing temperament; achievement oriented; self-esteem; hope, faith, belief in God, morality, trust; empathy and altruism; and locus of control; Social, interpersonal skills, including creativity; persistence; humor; communication; problem solving; impulse control; seeking trusting relationships; social skills; and intellectual skills.

What is resilience?

Recognizing features of resilience did not mean there was agreement on what resilience is; how to define it. Defining resilience is a continuing problem (Kaufman, Cook, Arny, Jones & Pittinsky, 1994) and there is a lack of consensus about the domain covered by the construct of resilience; i.e., its characteristics and dynamic (Gordon & Song, 1994). At a recent meeting the author attended, the argument was that if there is no instrument measuring resilience, no research can be conducted on the subject! Some languages do not yet have an equivalent word (Kotliarenco & Duenas, 1993). Spanish, for example, has no word for resilience in psychological literature but, instead uses the term "la defensa ante la adversidad (Grotberg, 1993)". French has the word but is questioning whether the concept is viable in the behavioral sciences, with increasing acceptance of its appropriateness (Manciaux, 1995).

But on examining the literature, there is a good deal of agreement on what the factors or features of resilience consist of. The problem of defining resilience as a construct may not be for lack of agreement on many of the factors and characteristics of resilience; rather, the problem may be more related to the dynamic interaction of the resilience factors, and the sources of resilience factors; e.g., internal/external; resources/skills.

A definition of resilience that appears to incorporate the literature and is used in the International resilience Project is: Resilience is a universal capacity which allows a person, group or community to prevent, minimize or overcome the damaging effects of adversity. Resilience may transform or make stronger the lives of those who are resilient. The resilient behavior may be in response to adversity in the form of maintenance or normal development despite the adversity, or a promoter of growth beyond the present level of functioning. Further, resilience may be promoted not necessarily because of adversity, but, indeed, may be developed in anticipation of inevitable adversities.

Launching of the International Resilience Project

The International Resilience Project is being conducted to ask a new question: What are parents, teachers, other adults and children themselves doing to promote resilience in children? The reason for asking this new question is to go beyond the retrospective and concurrent studies which found children already resilient and then attempted to identify what resilience factors or features they possessed or demonstrated that seemed to help them overcome the adversities they experienced. It seemed important to determine how children became resilient, how they developed the resilience features, how resilience could be promoted.

The project was international in scope primarily because of the growing interest in resilience as reflected by conferences involving resilience in different parts of the world. The Civitan International Research Center, University of Alabama at Birmingham, the primary sponsor of the Resilience Project, encouraged an international approach to the study in line with their new role in international research. They accepted the subject of resilience as an appropriate focus for an international effort. To assure international involvement and perspective, an Advisory Committee was established in early in 1993 representing UNESCO, Pan American Health Organization (PAHO), WHO, the International Children's Center (ICC), the International Catholic Child Bureau (ICCB), and, later, the Bernard van Leer Foundation. Their role is to provide suggestions and criticisms to the International Resilience Project.

The Research

The design and instruments used in the Project incorporate the following assumptions:

a. resilience factors that are used in response to constructed situations of adversity, and in reporting a recent personal experience of adversity involving a child, are, in fact, promoting resilience in the children;

b. adversity is not limited to man-made disasters such as war, famine, poverty, confinement, refugee status, etc., or to natural disasters such as earthquakes, hurricanes, floods, droughts, etc. Adversity may occur in everyday life in the form of divorce, abandonment, abuse, alcoholism, stabbing, illness, death, robberies, loss of home or job, moving, accidents, murder. Resilience may be promoted not necessarily because of adversity but, in fact, may be promoted in anticipation of inevitable adversities;

c. the early years of development are accepted as a critical time for acquiring many of the basic skills, attitudes and values that tend to remain over the life span. Werner (1993) specifically stated that children 11 years old of age and younger are the most likely age group to develop many resilience factors;

d. the Erikson developmental model is an appropriate model to use internationally, in spite of its lack of addressing gender differences. And while there is concern for western models for international research (Wade, 1993) many studies (Grotberg & Badri, 1992) have found such models useful when: i. applied without rigid age division lines; ii. using flexibility in noting behaviors in observation; iii. using culturally adaptive measurement of developmental status; and iv. being flexible in intervention activities. Measurement instruments lend themselves quite readily to translation and cultural adaptation (Badri & Grotberg, 1984).

The design for the International Resilience Project includes the following:

a. 15 Situations of adversity which were designed to address age groups 0-3; 4-6; and 9-11. An example of a Situation for each age group is as follows:

Two year old Frieda is at the market with her parent (caregiver). She grabs some sweets from a

tray and begins to put them in her mouth. Her parent tries to take the sweets away because she cannot pay for this treat. Frieda shouts, NO! MINE! arches her back and stiffens all over.

Tina is eleven and Clark is six years old. They are in the house alone. Tina is washing some dishes and Clark is putting his toys away in a box. It is almost time for lunch and they are waiting for their mother to come home. Suddenly, Tina hears Clark scream, "My foot is caught! Oh, it hurts!" Tina rushes to Clark.

Respondents answered the following questions for each Situation of adversity:

(For adults or someone in charge)

What did the adult do?
How did the adult feel?
What did the child do when the adult did that?
How did the child feel?
How did things come out or how are things now?

(For children)

What did the adult do (except when no adult was around the question became, What did the child in charge do?)
What did the child do when the adult (or person in charge) did that?
How did the child feel?
How did things come out or how are things now?

The same questions were used when the adult or the child reported a recent personal experience of adversity that involved the target child.

A number of standardized tests were used to validate the selection of resilience factors that were assumed to measure social skills, locus of control as an internal strength, and the parental contribution resilience through bonding.

Participants from 30 countries joined the International Resilience Project. Data from the first 14 of these countries submitting their data are included in this report. The participants were provided a Guidance statement of the methodology and a Manual for the Training of Interviewers, as well as a packet of the Situations and Questions to be answered. The intent of the Guidance and Manual was to provide some common methodology and training for the participants. A demographic information sheet gathered data about the family and reports of recent experiences of adversity. Those who wished to include the standardized tests were provided them.

Data received between September, 1993 and August, 1994 are included and are from the following countries: Lithuania, Russia, Costa Rica, Czech Republic, Brazil, Thailand, Vietnam, Hungary, Taiwan, Namibia, Sudan, Canada, South Africa, and Japan.

Scoring for resilience promotion

The unit of scoring responses to the Situations and reports of Personal experiences was the complete episode of the response; i.e., there was a beginning, a process and an ending, each part of which used resilience factors for promoting resilience in the children. The unit of the episode was selected for scoring because different parts of the response may or may not be acts promoting resilience. Many episodes had mixed responses. For example, a parent may provide loving, trusting support but prevent the child from testing his or her own need for autonomy, thus making the child overly dependent on parental protection. Scoring was a 1 for a non-resilience promoting response; 2 for a response mixing resilient and non-resilient promoting behavior; and 3 for a response indicating resilience promoting behavior.

When a response was scored a 3, the resilience factors derived from the literature and presented earlier were used to identify which resilience factors were used in promoting resilience. A further scoring involved identifying the specific external support and resources; the internal, personal factors used; and the social, interpersonal skills used. It was not necessary to draw on factors from each of the categories to score an episode as promoting resilience. What was important was the successful process of overcoming the adversity.

Findings

Data provided in the findings came from the 14 countries identified above. The population consisted of a total N of 589 target children and their families or caregivers; 48% are girls and 52% are boys. Most of the children were 9 to 11 years old (51%) with 29% ages 4 to 6 and 18% ages 3 and under. 65% of the children were healthy by WHO standards relating age to height, and 90% of the children were in some kind of school situation. 80% of the caregiver respondents were parents, with 20% being teachers or other caregivers. 85% of the families were in some kind of urban or semi-urban setting, including compounds, separate section of a town or suburb. 18% of the fathers were absent, with 3% absent mothers. 46% of the target children have one or more older siblings and 45% have one or more younger siblings. The mean size of families, including all who lived in the same residence, was 5.58, with an average family size of 3 to 5. Some families had members of 10 to 15 which affected the mean. 49% of the fathers had education beyond high school and 47% of the mothers had education beyond high school. 9% of the families reported a serious recent outside problem and 40% reported a serious recent intra-family problem. The cultural/ethnic identity broke down into 9% with a religious identity; 27% with a national identity; 13% with a racial identity; 27% with a tribal identity; and 10% with a mixed national/racial.

More older children responded than younger children, mainly because the participants conducting the research found them able to respond in groups and read the Situations for themselves. Where younger children were involved, the parent often had to be invited into the place of the interview or the interviewer had to go to the home. Further, it was difficult to elicit responses from the children. The few target children under 3 was consistent with the decision to add that age group, as several participants stated they worked with families having these young children and not older children, and wanted to involve such a population.

The health information is suspect because many of the children were in cultures where smallness is not asign of ill health, but of local genetic characteristics. The high percentage of children in a school setting and of parents with higher education is a reflection of the places services were provided these families by the participants or where the children were available in the school setting. Also, many countries provide more education as a political policy and this does not reflect the socio-economic level of a family. Level of education is not the indicator of socio-economic level in many countries. An interesting incidental finding, however, is that the correlation between father's level of education and the child's scores on resilience was not significant, while the correlation of the mother's level of education and the child's scores on resilience was low but positive; i.e., .208

The 6 major outside problems the family experienced within the preceding 5 years were, in rank order: robberies; war; fires; earthquakes; floods; and car accidents. The 6 major within-family problems the family experienced within the preceding 5 years in rank order: death of a parent or grandparent; divorce; separation; illness of parent or siblings; poverty; and the family or a friend moving.

The ethnic/cultural identities were of particular interest as all the families were in a nation; yet only 27% made that the prime identity, with another 10% combining national and tribal identities.

Evidence of resilience promoting behavior

Overall, 38% of adult responses had resilience promoting scores of 3, with 38.3% of the adults with children 6 and under having resilience scores and 37.6% of adults with children 9 to 11 having resilience scores. There is virtually no difference in parents' scores regardless of the ages of their children. For children 4 to 6, 11.6% had resilience scores of 3, and for children 9 to 11, 31% had resilience scores of 3. The overall average of resilience scores of 3 for all children was 24%.

Adults, on the whole, promote more resilience than children, and older children promote more resilience than younger children. These findings suggest that the promotion of resilience depends more on the behavior of parents and adults for children 6 and under, while children 9 to 11 do as much to promote their own resilience as do their parents and other adults. But, it is important to note that these percentages of resilience scores of 3 are relatively low for both adults and children. When well over half of the responses show little or no resilience promotion, the case for such promotion becomes more important. Further, the role of adults in the promotion of resilience in children has new significance. It may well be true that resilience in children is dependent on adult contributions to its promotion. Resilience does not develop in a vacuum; it is within a context. As children become older they appear to assume a larger role in the promotion of their own resilience, still in the context of their supports, their acquired skills, and their enhanced inner strengths. The challenge, then, is how to help younger children be more able to promote resilience, how to help adults contribute to this more effectively and how to help all adults and children become more resilient.

Reports of Personal Experiences in Addressing Adversities

Each adult and each child interviewed was asked to report on a recent personal experience of adversity that included the target child. The data reflect the fact that only 40% of the adults reported a personal experience and 57% of the children reported such an experience. Even when allowing for children

who were too young to report a personal experience, the relatively higher percentage reporting such an experience by children suggest a greater willingness to provide a report. The researchers at the country level frequently stated that people in their country did not want to admit to a problem, did not want to reveal a problem or were superstitious about the consequences of reporting such a problem.

Comparing total percentages of resilience scores of 3 for the structured Situations with total percentages of such scores for the reporting of a Personal Experience, the following was found: 50% of the children from 4 to 11 who reported a personal experience had resilience scores of 3; and 42% of the adults had such a score. For responses to the Situations, 38% of the adults and 24% of children from 4 to 11 had resilience scores of 3. It seems clear that parents are consistent in their resilience promoting behavior, but that children show much more promotion of resilience in their real experiences that in structured situations.

Resilience features and dynamics used

The research findings provided information indicating which resilience features were used most frequently to promote resilience in children and what dynamics of resilience features were used most frequently.

The most frequently used resilience factors or features were these: from External supports and resources - trusting relationships, structure and rules at home, parental encouragement of autonomy, and role model; from Internal, personal strengths, - sense of being lovable, autonomy, self-esteem, hope and faith and trust, and locus of control; from Social, interpersonal skills - communication, problem solving, and impulse control.

One dynamic consisted of having a trusting relationship, having a sense of being lovable, and being able to communicate. Another dynamic was parental encouragement for autonomy, and problem solving. Another dynamic was structure and rules at home, locus of control, and impulse control And still another dynamic was role model, hope and faith and trust, and seeking a trusting relationship. Caregivers who provided a trusting relationship and were role models, for example, but did not encourage autonomy, frequently had children who did not respond to Situations or the Personal experience with evidence of resilience behavior. Parents who promoted a good deal of autonomy with a minimum of a trusting relationship, frequently had children who were autonomous but did not trust adults. These dynamics have importance as they go beyond many programs and much research on one factor or feature of resilience, such as self-esteem or problem solving.

The Guide to Promoting Resilience in Children: Strengthening the Human Spirit

Research on human development and behavior does not necessarily lend itself to application to programs. The International Resilience Project, however, was designed so that such application might be possible. Previous research on resilience sought those features of children already "beating the odds" that differentiated them from children who were overwhelmed by the odds. These retrospective studies as well as the concurrent ones, in which children were observed or interviewed to identify special features, were important, but insufficient for application. It seemed desirable to attempt to determine what were parents, other adults and children themselves doing to promote resilience in

children. What these people did should provide information basic to a guide for ways to promote resilience in children.

Clarifying the vocabulary of resilience

Those who work with children and families need to have tools to work with that help them apply information to particular situations or programs. They need tools that are simple to communicate, clear in meaning, and adaptable to use. Such changes were necessary from the findings of the International Resilience Project. For example, the long and complex definition of resilience could easily be simplified as follows: Resilience is the human capacity to face, overcome, and even be strengthened by the adversities of life.

The resilience features were a greater challenge. It was necessary to reduce the number of features from 26 to something more manageable and yet to retain the essence of all of them and also reflect the findings from the International Resilience Project; and it was necessary to find some clear and meaningful classification system for the different sources of resilience. Instead of External supports and resources, the term **I HAVE** is used; instead of Inner, personal strengths, the term **I AM** is used; and instead of Social, interpersonal skills, the term, **I CAN** is used. With that classification, the resilience features were collapsed as follows:

I HAVE

People around me I trust and who love me, no matter what
People who set limits for me so I know when to stop before there is danger or trouble
People who show me how to do things right by the way they do things
People who want me to learn to do things on the own
People who help me when I am sick, in danger or need to learn

I AM

A person people can like and love
Glad to do nice things for others and show my concern
Respectful of myself and others
Willing to be responsible for what I do
Sure things will be all right

I CAN

Talk to others about things that frighten me or bother me
Find ways to solve problems that I face
Control myself when I feel like doing something not right or dangerous
Figure out when it is a good time to talk to someone or to take action
Find someone to help me when I need

The Guide was developed to help people working with children and families incorporate resilience into

their work as they help parents and children promote resilience in the children (Grotberg, 1995).

Effectiveness of Interventions

The Guide provided the basic material for conducting workshops to test the effectiveness of the intervention. Workshops and follow-up actions provide information on (1) the changes participants made as a result of the Workshop; and (2) the follow-up 2-4 months later to determine the continuing actions in the promotion of resilience in children.

Workshops and presentations were initially conducted in 1995 in Helsinki, Finland with hospital staff at a Children's Hospital; Prague, the Czech Republic with psychologists; Budapest, Hungary with child caregivers; the Hague, the Netherlands with staff of the Bernard van Leer Foundation; Taipei, Taiwan with members of the International Council of Psychologists; Quezon City, the Philippines with members of the End Child Prostitution in Asian Tourism (ECPAT); Mandaluyong City, the Philippines with psychologists from the Psychological Association of the Philippines; and Bethesda, Maryland, USA with staff of the health and social services staffs working with children and families in the Army, particularly families with a disabled child.

The purpose of the workshops was to prepare participants for promoting resilience in children by incorporating resilience promoting behavior into their work. The Workshops and presentations held in 1995 provided the experience necessary to test the responsiveness of participants to achieving the following goals: 1. Use the language of resilience; 2. Apply resilience promoting responses to situations of adversity; 3. Give examples of the dynamics of promoting resilience; 4. Report accurately on when they have promoted resilience in their work and when they have not; 5. Present examples of how they will incorporate the promotion of resilience into their work with children and families.

Examples of two workshops, held in 1996, one in Banff, Canada, for members of the International Council of Psychologists and the other in Virginia, USA with faculty of a school, are provided. They are examples of the effectiveness of the workshops by gathering data from pre- and post-testing at the Workshops and gathering follow-up data to determine the continuity of promoting resilience in children. At each workshop the participants were presented with the following constructed Situation and asked to respond to the accompanying questions:

> Eight year old Sean is on the school playground where there is a tree. He climbed up the tree and is sitting on a limb. Two other boys watch Sean and decide to pull him down, just for the fun of it. They grab him by the legs and Sean kicks one of the boys in the face, causing blood to come out of his mouth. The injured boy screams and a teacher comes out of the building.

The questions posed are: What would you do? How would you feel? What would the children do when you took that action? How would the children feel? What do you think the outcome would be or how would it end?

The major changes (25% to 41.9%) in ways to promote resilience in children for the Banff Workshop, included: People around me I trust and who love me, no matter what (I HAVE); Glad to do nice things for others and show my concern; Respectful of myself and others; and Willing to be responsible for

what I do (I AM); and Talk to others about things that frighten me or bother me; Find someone to help me when I need it (I CAN). The remaining resilience features were increased as well but not to the same levels. The changes held up after a 4 months written follow-up report in which the respondents also indicated how they are incorporating resilience into their work.

The major changes (25% to 30%) in ways to promote resilience in children for the Virginia school faculty included: People who show me how to do things right by the way they do things (I HAVE); Glad to do nice things for others and show my concern (I AM); Find someone to help me when I need it; Talk to others about things that frighten me or bother me; Control myself when I feel like doing something not right or dangerous (I CAN). Most of the remaining resilience features were increased as well but not at the same levels. The changes held up after a 2 months follow-up session.

For both workshops, the outstanding changes included talking more with children, sharing feelings, showing more empathy, being less concerned about punishment (the faculty) and focusing less on procedure and more on the general promotion of resilience in the clients (the psychologists).

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